What Are the Benefits of a New Placebo Language?

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ABSTRACT This article examines three common strategies for dealing with the problems generated by the terms *placebo* and "placebo effect." These strategies are to redefine, to reconceptualize, and to eliminate our placebo language. The promise of these strategies is that a new language for talking about placebo phenomena may deliver clinical, ethical, and methodological advances. However, the nature and impact of these advances is rarely explored in detail. This article surveys some of the promised benefits of new terms such as "meaning response" and "contextual healing." The benefits are broadly similar across these strategies, but while they allow for clearer descriptions of phenomena and wider appreciation of the contextual aspects of medical practice, the open challenge for these strategies is not just to promise, but to show, the practical significance of their approaches to understanding placebo phenomena.

A New Language for Placebo Phenomena

A common theme in placebo studies is that the terms *placebo* and "placebo effects" are confusing, misleading, and sloppy, and that there are no agreed definitions. Indeed, many authors treat the

conceptual difficulties raised by placebos as a call to action and propose new definitions and reconceptualizations, or even propose abandoning the term altogether (Gøtzsche 1994; Howick 2017; Louhiala and Puustinen 2008; Miller and Kaptchuk 2008; Moerman 2002b; Nunn 2009a; Turner 2012). The promise of these approaches is that a new language and new metaphors for thinking about placebo phenomena may deliver clinical, ethical, and methodological advances. However, the nature and impact of these promised advances is rarely explored in detail. In this article I survey some of the most prominent ways to rethink placebo phenomena and the kinds of advantages they are claimed to offer.

Strategy 1: Definition

There have been various attempts to tame placebo phenomena by stipulation (see, for example: Grünbaum 1981, 1986; Shapiro and Morris 1978; Shapiro and Shapiro 1997). Most recently Jeremy Howick (2017) has proposed a refined version of Grünbaum's definitional framework. The two most valuable insights from Grünbaum and Howick's work are the separation of treatments into their "characteristic" and "incidental" features, and the recognition of "therapeutic theory" as the determinant of which features are characteristic or incidental. To oversimplify their framework: for a given condition and individual, a placebo is defined as a treatment where the characteristic features (according to a specific therapeutic theory) have no effect (positive or negative) on the condition. Placebo or nocebo effects are positive or negative effects, respectively, of the incidental features of a treatment on a condition, in a particular individual. Deconstructing treatments into their constituent features is a powerful move. Grünbaum and Howick build a definitional framework on this insight, but as I outline below, other strategies for thinking about placebo phenomena also crucially incorporate it.

Howick also claims that his definitional strategy falsifies a premise on which many reconceptualizations of placebo are based, namely that reconceptualization is necessary because a consistent definition is not possible. This is unfair for at least one reason. The problem motivating all the strategies discussed in this article is how placebo phenomena should be understood: no strategy has self-evident priority. The criterion for judging between them, I suggest, is what benefits they offer. If a

consistent definition is possible, there may still be good reasons to adopt a more radical reconceptualization.

Strategy 2: Reconceptualization

Various ways of reconceptualizing placebo phenomena have been proposed, and they draw on broadly similar insights. Franklin Miller and Ted Kaptchuk (2008) use the term "contextual healing" to emphasize the fact that a common element in "placebo effects" is a response by the patient to the various contextual (one might say *incidental*) features of a treatment situation. They state that contextual healing is "That aspect of healing that is produced, activated or enhanced by the context of the clinical encounter, as distinct from the specific efficacy of treatment interventions" (224). Similarly, Pekka Louhiala and Raimo Puustinen (2008) argue for replacing the term "placebo effect" with "care effect," which, like Miller and Kaptchuk's proposal, is designed to refocus attention on "the phenomena that take place during the consultation and lead to beneficial therapeutic results . . . that may be considered to be the effect of being treated or cared for" (108; see also Blease 2012). Still other authors propose alternative terms such as "response to the healing situation" (Papakostas and Daras 2001), again employing new terms in order to focus attention on context.

In these different reconceptualizations, what counts as a feature of the treatment context is necessarily broad. It includes the microsocial level—for example, patients responding to the empathy and reassurance of individual members of their health-care team. It also includes, at the more general level, patients responding to the cultural connotations of features of a given situation, such as the use of particular colors, brands, and prestige and drama that medical treatments may tap into.

Building on the recognition that context factors are key in reframing placebo phenomena, Daniel Moerman and Howard Brody both emphasize meaning as the mechanism by which context makes a therapeutic impact (see for example, Brody 1988; Moerman 2002b, 2013; Moerman and Jonas 2002). Moerman characterizes the "meaning response" as "the physiologic or psychological effects of meaning in the origins or treatment of illness" (Moerman and Jonas 2002, 472), noting elsewhere that "meaning

responses follow from the interaction with the context in which healing occurs" (Moerman 2002b, 16). Similarly, Brody (1988) emphasizes that it is the "symbolic or ideological dimensions of the physician-patient encounter" that is crucial to understanding placebo phenomena (150). These "meaning theories" may compete with or complement expectation or conditioning accounts of the mechanism by which context affects patients (Price, Finniss, and Benedetti 2008). To illustrate their complementarity, for example, how might verbal instructions create expectations other than through their meaning to an individual? The broadness and anthropological richness of a concept like meaning leaves open a host of possible connections and relationships to explanations couched in terms of expectations or conditioning. (But as the eliminativists below argue, this may be more of a vice than an analytical virtue.)

The key point I wish to highlight is that there is much common ground between the different reconceptualizations. An important consequence of all of them is that the locus for explaining placebo phenomena shifts towards "what people know and understand about medicine; what they experience about healing, what healing processes mean" (Moerman 2002b, 20). Furthermore, it is also an open question how these reconceptualizations compete with each other (or with the definitional framework of Grünbaum and Howick). The terms "contextual healing," "meaning response," and Howick's "placebo effect" are not coextensive, but neither are they contradictory. The difference between the different reconceptualizations is, I suggest, mainly one of emphasis.

Strategy 3: Elimination

In contrast to authors who have argued that placebo phenomena should be reconceptualized in different terms, there are also those who argue that we should instead simply eliminate placebo language (Gøtzsche 1994, 1995; Nunn 2009b, 2009a, 2009c; Turner 2012). For example, Peter Gøtzsche (1994) expresses this eliminativist view: "we should divert our focus of interest away from the essentially unsolvable problem of whether or not an intervention is a placebo towards the magnitude of the measured effect and the choice of effect variable" (926). Gøtzsche is pessimistic about the project of providing consistent and coherent definitions of terms like *placebo* or "placebo effect." Instead, he suggests a more

pragmatic project to investigate whether and to what extent different features of treatment have therapeutic effects. Moreover he places all features an equal footing and makes no distinction between characteristic and incidental features.

Regardless of whether it is correct that the placebo problem is "essentially unsolvable," some authors have expanded on Gøtzsche's idea and offered arguments designed to show that placebo language is unnecessary and unhelpful however it is conceptualized. Robin Nunn (2009b, 2009a, 2009c) and I (Turner 2012) have both argued that placebo language should be eliminated in favor of more precise descriptions of the underlying phenomena, so "there will be no hiding behind the skirts of the emperor's new placebo" (Nunn 2009a). One key difference between these eliminative strategies and the reconceptualizations above is that overarching terms such as *meaning, context,* or *care* are rejected in favor of explanations that focus on specific details, such as the "magnitude of the measured effect" and the "effect variable." Nunn and I have separately argued that the heterogeneous ensemble of elements falling under notions like "context" or "meaning" (or like the term *placebo* itself) render those higher-level concepts similarly unnecessary and unhelpful. As explained below, the focus on the specific details of placebo phemonena brings greater descriptive accuracy to discussions.

The core insight of the eliminative strategy is that there are no concepts that easily capture placebo phenomena. However, the strong claims about the benefits of the eliminative strategy are insufficiently defended. The key task for the eliminative strategy is to show that placebo language and similar reconceptualizations or definitions are indeed unnecessary and unhelpful. While Nunn and I have made progress by showing that the terms are not necessary because it is possible to use more precise descriptions, it is less clear that we have shown that placebo language is unhelpful, either by providing good examples where it causes significant problems, or by providing good evidence that elimination would bring significant benefits.

What Are the Benefits of These Strategies?

These strategies all promise to enhance our understanding of placebo phenomena, but why should we

alter our placebo language? Perhaps our muddled talk of placebos and placebo effects is philosophically problematic, but also adequately functional. It is one thing to ask for more precision, but another to know what level of precision is appropriate. Unless our placebo language is leading to clinical, ethical, or methodological mistakes being made, then the proposals above, in an important sense, may not matter.

In this section I survey some of the promised benefits of refining our ways of speaking about placebo phenomena, notably clarity and practical impact.

Clarity

The most important aim of all three strategies is to provide greater clarity about placebo phenomena. Outside of the field of placebo studies, common notions are deployed when describing placebos and placebo effects, including the idea that placebos are inert and inactive; that placebo effects are nonspecific rather than specific, subjective rather than objective; or that they consist of a background noise of other biases (such as natural history, regression to the mean, the Hawthorne effect, and so on) rather than a genuine effect (see Ernst and Resch 1995). Within the field many authors highlight the ways that these notions do not stand up to scrutiny (see in particular Miller and Brody 2011). Indeed, one apparent and frequently noted puzzle is that an inert or inactive placebo, seemingly by definition, cannot be the cause of the placebo effects that contribute to the effectiveness of a treatment (Moerman 2002b). Authors deploy this puzzle to hint at the promise being made: if one stops thinking about so-called "placebo effects" as *placebo* effects, then that opens up space to think about those effects in noncontradictory and more accurate terms. For Moerman and Jonas (2002), for instance, a key consequence of greater conceptual clarity is the realization that "the one thing of which we can be absolutely certain is that placebos do not cause placebo effects" (471).

The various reconceptualization strategies propose new terms that help us understand the underlying phenomena better and describe them more accurately. As Louhiala and Puustinen (2008) argue, the aim of this is to put "the nature and existence of the placebo effect on firmer ground" (107). There is an important sense here in which the reconceptualization strategies do compete with each other,

namely, that their particular emphasis on context, care, or meaning represents the clearest and most rigorous way to conceptualize placebo phenomena. So while they may be compatible ways to carve up placebo phenomena, they may also have different analytical merits. For instance, do we gain greater clarity by emphasizing features of those treatments that may be therapeutically relevant—certain kinds of context, for example—or do we gain greater clarity by emphasizing the mechanisms—meaning, for example—by which those features become therapeutically relevant?

Like the reconceptualization strategies, the elimination strategy promises to bring better understanding and more accurate and detailed descriptions to placebo phenomena. The difference, however, is that the eliminativists claim that no overarching concepts like meaning or new concepts like "contextual healing" are needed in order to provide that clarity.

The benefits of any one conceptualization or of elimination turns on being able to demonstrate that the descriptions offered have the most analytical merit. In contrast, attempts to provide a consistent definition of terms like *placebo* or "placebo effects" promise a different kind of clarity. Rather than introducing new ways to think about the phenomena, they instead offer a precise stipulation of how to use the terms appropriately and avoid contradictions.

Practical Impact

Conceptual clarity is not just thought to be beneficial for its own sake but also for its potential practical value—that is, for its clinical and methodological consequences. For example, statements such as these are common:

> Practitioners can benefit clinically by conceptualizing this issue in terms of the meaning response rather than the placebo effect. (Moerman and Jonas 2002, 474)
>
> [A]n adequate account of the notion of a placebo . . . could have practical implications for clinical trial design. (Howick 2017, 1369)

One area where the methodological implications of different strategies for rethinking placebo phenomena is best developed is around what makes a "placebo control" legitimate. For example, I have

argued that adopting the eliminative strategy forces one to ask for greater detail about the measures taken in the control group of a placebo-controlled trial, detail that may otherwise be obscured or glossed over by the use of the term *placebo* (Turner 2012). Some evidence for the benefit of more detailed descriptions of placebo controls is provided by Beatrice Golomb and colleagues (Golomb 1995; Golomb et al. 2010). They found that placebo controls used in randomized trials are often poorly described, making it difficult to judge the adequacy of the placebo control being used. For instance, dummy pills given to the control group may contain undisclosed excipients that affect the condition being investigated, or they may be sufficiently different from the pills in the treatment group that blinding is compromised, perhaps because the dummy pills do not contain ingredients that mimic side-effects of the treatment (Greenberg and Fisher 1994). More speculatively, the technique of network meta-analysis, which infers comparative effectiveness from indirect treatment comparisons, may be at risk of error if one assumes that there is a transitive relationship between the effectiveness of treatments from two randomized trials on account of both using controls that are called "placebos" (Mills, Thorlund, and Ioannidis 2013). (Harald Walach's "efficacy paradox" [2001] identifies a similar issue.) It seems that beyond these particular examples, there is relatively little evidence for claims that there are systematic methodological problems caused by the use of current placebo language, or that these are sufficiently serious that eliminating placebo language would be a proportionate way to solve the occasional problems that do arise.

A second suggestion for the practical impact of the strategies above is that they can stimulate new research avenues for understanding and exploiting placebo phenomena further (see, for example, Brody 2000). This is particularly true for the various reconceptualizations of placebo phenomena that direct our attention to areas for further research that were previously ignored or obscured by traditional notions of placebos and placebo effects. For instance, Moerman and Jonas (2002) are instructive when they note that: "Interesting ideas . . . are impossible to entertain when we discuss placebos; they spring readily to mind when we talk about meaning" (609; see also Moerman 2013). Similarly, Miller and Kaptchuk (2008) argue that their term, "contextual healing," corrects the fact that context is typically "off the radar screen":

> Conceptualizing the placebo effect as contextual healing suggests that theoretical understanding and scientific experimentation related to this phenomenon should aim at isolating and elucidating those factors in the clinician-patient encounter that contribute causally to improvement in outcomes for patients. (224)

These and similar suggestions represent a research program for placebo studies that is well developed today (Benedetti 2014; Miller et al. 2013). However, the field of placebo studies has generated its insights without adopting any radical strategy for thinking about placebo phenomena. It seems that little reconceptualization is necessary beyond the recognition that placebo phenomena can be framed in the broader terms of the psychosocial context surrounding a patient. This is the most minimal way of using the insight from those advocating new terms such as meaning response, care effects, and so on. For more thorough-going reconceptualizations, or for the eliminative strategy, at best they suggest what more might be possible if the terminology and connotations of common notions of placebo phenomena could be replaced entirely.

A third area where a new placebo language is claimed to offer potential benefit is shedding light on ethical problems with the clinical use of placebos and placebo effects. Here the claim is that failure to think correctly about placebo phenomena has hampered their effective ethical exploitation (Moerman 2002a). A common implication of both the reconceptualization and elimination strategies is that they undermine simple chains of reasoning in which a treatment is unethical simply because it is a placebo or because its effectiveness is a placebo effect. For example, Louhiala and Pusstinen (2008) argue that reconceptualizing placebo phenomena escapes the pejorative "connotations and contradictory meanings" of placebo language, thereby removing a kind of descriptive bias in the reasoning above (109).

Following on from this, reconceptualizations of placebo phenomena also suggest how to expand one's ethical reasoning to recognize all the features of treatments that are likely to contribute to its effectiveness. They permit one to reframe ethical questions in terms of how to optimize the incidental but therapeutically useful features of treatments (Annoni and Miller 2016; Blease 2012; Finniss et al. 2010; Gaab et al. 2016). For instance, the issue of deception, often raised in discussions about the ethics of

placebos, can be reframed as an issue that cuts across rather than defines those discussions (Foddy 2009, 2011). The question of when, if at all, one can give effective treatments ethically but deceptively may have a large impact on the use of dummy pills or sham techniques, but the relevance of deception to the debate is far less when the key question is how the effects of the incidental features of treatments can be maximized, such as delivery by empathetic and reassuring clinicians. Against this view, Stewart Justman (2013) argues that maximizing context effects is largely equivalent to deceiving or misleading patients and amounts to little more than increasing the "pomp and circumstance of medical care." Such a narrow view of context effects is clearly denied in all various reconceptualizations of placebo phenomena, however.

Reconceptualizations that emphasize contextual factors widen the ethical debate. Beyond elements of "good doctoring," some context factors may not be ethically trivial even if they do not involve deception. For instance, questions have been raised about clinicians' obligations to disclose how and what to inform patients about "open-label placebo" treatments or the various incidental features of a treatment being optimized, as well as about how to inform patients in situations where the incidental and characteristic features of a treatment are hard to untangle (Blease 2012; Blease, Colloca, and Kaptchuk 2016; Gaab et al. 2016; Justman 2013; see also Maddocks et al. 2016).

The most convincing benefit of both reconceptualization and elimination strategies is to widen the terms of the ethical debate by forcing one to unpack the notions of a placebo or placebo effect and their role in ethical reasoning. Placebo phenomena enter ethical debates in many different ways, from thorny issues around appropriate optimizations of treatment context to deliberate deception that induces beneficial expectations in patients. Widening the debate and exploring new issues is an important consequence of reconceptualization and elimination strategies, but the translation into practice is less visible. For example, it remains to be seen how these insights will change ethical codes of practice for health-care professionals or affect consent forms or consent-taking procedures in research. Of course, this may be a matter of time for the relatively new field of placebo studies, but it is none the less a current promise.

Conclusion

I have described three common strategies for dealing with the apparent problems that placebo phenomena generate: to redefine, to reconceptualize, and to eliminate our placebo language. While I have discussed them separately, they could also be said to belong on a spectrum: for example, definitions of placebo and placebo effects blur into reconceptualizations as they expand to incorporate different concepts. The boundaries between strategies are not important, because as I have shown, all the strategies make the same promise to provide greater clarity about placebo phenomena that both improves on existing, muddled, accounts of the nature of placebos and placebo effects and spurs clinical, methodological, and ethical innovation. No one strategy has a decisive argument for why it is the most beneficial. However, no matter which strategy one favors, moving away from the most common confusions surrounding the terms *placebo* and "placebo effect" creates space for more accurate and thought-provoking descriptions of phenomena and a wider appreciation of the contextual aspects of medical practice.

Contemporary placebo studies seem only to adopt a minimal shift in thinking about placebos and placebo effects, one that emphasizes the psychosocial contexts that produce placebo effects without fully embracing any of the various reconceptualizations, elimination, or redefinitions. Yet the key insights offered by the three strategies may not be heavily dependent on the actual terms used (or not used). That is to say, some of the most important insights are not about placebo language per se, but about viewing treatments as packages of incidental and characteristic features; emphasizing the therapeutic potential of contextual features (and meaning or symbolism as a mechanism); and focusing on the precise details of therapeutically relevant features of a treatment.

The emphasis on context and on the effectiveness of the incidental features of treatments is reframing the debate about the potential clinical uses of placebos and placebo effects. That these reconceptualizations have widened the debate much more so than meaning theories perhaps demonstrates that there is more utility in focusing on which features matter, rather than why certain features matter. However, beyond this, the benefits of a new placebo language seem modest. The open challenge for these strategies is not just to promise but to demonstrate the clinical and methodological significance of their

approaches to understanding placebo phenomena.

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